CENTENNIAL
MENTAL HEALTH CENTER
Moving lives forward

FINANCIAL HARDSHIP APPLICATION

The client will need to complete a financial disclosure form and provide documentation of proof of income. Appropriate documentation of financial hardship would be one or more of the following:

1. Documented proof that the client is below 125% of the current federal poverty guidelines. This can include documents such as:

    a) Pay check stubs
    b) Income Tax return
    c) Forms from Medicaid or other State-funded medical assistance
    d) Forms from employers or welfare agencies

2. Client has other circumstances that indicate financial hardship. These can be situations such as:

    a) Proof of bankruptcy
    b) Catastrophic situations (death or disability in the family, divorce)
    c) Or other documentation that shows that the client would be unable to pay medical bills and still be able to pay for other basic necessary expenses.

Income shall be annualized from the date of request based on the documentation provided and upon verbal information provided by the client. The annualization process will also take into consideration seasonal employment and temporary increases and /or decreases to income.

Completion of this application does not mean your request will be granted or that you will be relieved of financial responsibility.

All information relating to financial hardship requests will be kept confidential.

FINANCIAL DISCLOSURE FORM

Administrative Offices
211 W. Main St
Sterling CO 80751
Phone: (970) 522-4549 Fax: (970) 522-9544
www.CentennialMHC.org

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Please provide the following information so we may complete your application:

- ☐ Most recent IRS tax forms (Must be signed)
- ☐ Check stubs for the past 30 days for **all** persons employed in the home
- ☐ Unemployment statements for the past 30 days
- ☐ Driver's License or identification card for adults
- ☐ Proof of all other income received in the past 30 days
- ☐ Proof of all outstanding bills
- ☐ DHS Denial Letter
- ☐ Medicaid forms or card
- ☐ Attached financial statement (completely filled out and signed)

Please be sure to sign the attached financial statement. Your request will NOT be processed if this is not signed.

Please return all items (as applicable) on this checklist (in person or by mail).

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Financial statement payment plan/uncompensated services application.

Client Name:_____ Client #_____

Date(s) of Service:_____

Name of Responsible Party:_____

Relationship to Client:_____

Spouse:_____

Telephone:_____

Can we leave a message? ☐Yes ☐No

Address:_____

Number of Family Members (Living in the Household):_____

- Adults:_____ Children:_____

Employer:_____

Address:_____

If Unemployed, How Long?_____

Spouse's Employer:_____

Address:_____

Other Family Member's Employer(s):

(Include Member Name, Employer & Address)

_____

_____

_____

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Monthly family income & source

☐Client ☐Spouse ☐Responsible Party ☐Children Working

Monthly Salary (Gross)	$_____
Public Assistance Benefits	$_____
Unemployment Benefits	$_____
Social Security Benefits	$_____
Workman's Compensation	$_____
Child Support	$_____
Other (Alimony, Etc.)	$_____

Other living expenses:

Food	$_____
Clothing	$_____
Transportation	$_____
Other	$_____

I HEREBY ACKNOWLEDGE THAT THE INFORMATION GIVEN HEREIN IS TRUE AND CORRECT. I AUTHORIZE CENTENNIAL MENTAL HEALTH CENTER, INC. TO VERIFY ANY INFORMATION CONTAINED IN THIS DOCUMENT FOR THE SOLE PURPOSE OF ASSESSING FINANCIAL NEEDS.

_____ _____
Signature of Person Making Request Date

_____ _____
Signature of Spouse/Other Date

DO NOT WRITE BELOW THIS LINE- FOR OFFICE PERSONNEL USE ONLY

This document was received on _____(date)

By _____(Name/Title)

Approved Fee:_____

Approved by _____ Name/Title)

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